PRINTED: 06/12/2020 FORM APPROVED

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		125031	B. WING		05/20/2	2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
KOHALA I	HOSPITAL		OSPITAL ROAD HI 96755)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
	Health Care Assurance re-licensing survey or regulatory requirement Control; Resident About Misappropriation of R. Admission, Transfer I. Services; and Emerge facility was found to be Hawaii Administrative 94.1, Nursing Facilities regulatory requirement. Total residents: 20. Total	nts included, Infection use and Neglect, and esident Property; Discharge; Nursing ency Preparedness. The ne not in compliance with the Rules, Title 11, Chapter res requirements for the nt of Infection Control. There were no residents or ested positive for COVID-19. In control Dipropriate policies and nd implemented for the ntrol of infectious diseases siance with all applicable and rules of the department diseases and infectious	4 203	GLUCOMETER 1. How corrective action will be accomplished for those residents four have been affected by the deficient practice.		/25/20
Office of Lies	properly screening vis facility; and by using a could not be properly residents. Facility res	sitors prior to entering the a single use glucometer that sanitized for multiple sidents were potentially at le COVID-19 virus; and		All 5 - diabetic residents in-house hav their own glucometer-labeled with the name and placed in the medication ro for storage. Cleaning of the individua glucometer follows the industry guidel	ir om I	
		SUPPLIER REPRESENTATIVE'S SIGNATURI	Ē	TITLE	(X6) DATE

Electronically Signed 06/08/20

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(3) DATE SURVEY COMPLETED	
125031		B. WING		05/20/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
KOHALA I	JOSDITAL	54-383 HC	SPITAL ROAD			
ROHALA	TOSFITAL	KAPAAU,	HI 96755			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
4 203	Continued From page	e 1	4 203			
4 203	Findings include: 1) On 05/13/20 at approximately 10:15 AM, the two-member, state agency surveyor (SSA)1 and SSA2, surveying team approached the front main entrance of the facility. Observed an unmanned screening table prior to reaching the main entrance of the facility. Upon announcing the surveying team's presence, facility staff informed the surveying team that staff will screening surveyors prior to entering the facility. A security guard staff (SS)1 approached the main entrance, opened the double doors and allowed surveyors to enter about 3 feet into the facility. SS1 proceeded to take both SSA1's and SSA2's temperature via scanning thermometer and documented the results on a sheet. SS1 did not ask either surveyor any screening questions. SSA1 and SSA2 received a sticker from SS1 which indicating both surveyors were screened and cleared to enter the facility. At approximately 10:35 AM, SSA2 was allowed to enter the facility to conducted patient/staff observations. SSA2 stated she was not asked screening questions prior to entering the facility to conduct observations. On 05/13/20 at 12:40 PM, inquired with the Assistant Hospital Administrator (AHA) regarding the facility's policy and procedure for screening visitor and staff. AHA stated everyone is		4 203	2. How the facility will identify other residents having the potential to be affected by the same deficient practic 2 extra glucometers were purchased any future diabetic residents needing have their blood sugar level checks. Kohala Hospital will have a par of 2 eglucometers on hand at all times. 3. What measures will be put into place systematic changes made to ensure the deficient practice will not recur. All staff were in-serviced on the use of individual glucometers, use of glucometers and maintaining aseptical cleaning of the individual glucometers industry guidelines, and continue with annual CLIA competency on Point of glucose testing for all Registered Nursand Licensed Practical Nurse. CLIA competency is also added to new orientation training for all new hired nurses. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected a will not recur. i.e. what program will be into place to monitor the continued effectiveness of the systematic chang Charge nurse and Nursing management will monitor the use of the individual	for to ktra ce or hat f the field, per Care ses	
	visitor and staff. AHA screened prior to enter staff. The security start visitor/staff temperature questions provided by Control (CDC). If the elevated temperature	A stated everyone is ering the facility by security aff is expected to take ares and ask the screening by the Center for Disease		glucometers by auditing use of the glucometer 3 times per week for the month of May, weekly for the month of June, and monthly audits thereafter for next 3 months. ENTRY SCREENING for COVID 19 1. How corrective action will be		

Office of Health Care Assurance

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Hawaii Dept. of Health, Office of Health Care Assurance

NAME OF PROVIDER OR SUPPLIER 125031 STREET ADDRESS, CITY, STATE, 2IP CODE 54-383 HOSPITAL ROAD KAPAAU, HI 96755 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 1203 Continued From page 2 further evaluate the visitor/staff. Informed the AHA that upon entering the facility, SSA1 and SSA2 were not asked the screening questions. AHA confirmed SS1 should have asked SSA1 and SSA2 the CDC screening questions prior to giving both surveyors stickers which indicated the surveyors were thoroughly screened. On 05/19/20 at 10:15 AM, reviewed documentation provided by the facility regarding screening process. According to documentation screening staff should ask anyone who enters the facility the following: "In the last 14 days, have you had any of the following? 1. cough, 2. Shortness of breath or difficulty breathing, 3. fever, 4. chills, 5. repeated shaking with chills, 6. Muscle pain, 7. Headache, 8. Sore throat, 9. New loss of taste or smell, 10. Have you been in close to the following to the following to post. 12500 SUMMARY STATEMENT OF DEFICIENCY: STAGET ADDRESS, CITY, STATE, 2IP CODE 54-383 HOSPITAL ROAD KAPAAU, HI 96755 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 203 4 203 4 203 4 203 4 203 4 203 4 203 4 203 4 204 4 205 4 205 4 206 4 207 4 208 4 209	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 54-383 HOSPITAL ROAD KAPAAU, HI 96755 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) 4 203 Continued From page 2 further evaluate the visitor/staff. Informed the AHA that upon entering the facility, SSA1 and SSA2 were not asked the screening questions, AHA confirmed SS1 should have asked SSA1 and SSA2 the CDC screening questions prior to giving both surveyors stickers which indicated the surveyors were thoroughly screened. On 05/19/20 at 10:15 AM, reviewed documentation provided by the facility regarding screening staff should ask anyone who enters the facility the following: "In the last 14 days, have you had any of the following? 1. cough, 2. Shortness of breath or difficulty breathing, 3. fever, 4, chills, 5. repeated shaking with chills, 6. Muscle pain, 7. Headache, 8. Sore throat, 9. New STREET ADDRESS, CITY, STATE, ZIP CODE 54-383 HOSPITAL ROAD KAPAAU, HI 96755 PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE COMPLETE DATE A 203 4 203 4 203 4 203 4 203 ACCONTINE THOROPT SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) A 203 ACCONTINE THOROPT SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE ACCOMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CAPACULATION OF COMPLETE DATE A 203 A 204 A 203 A 205 A 205 A 2	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE 4 203 Continued From page 2 further evaluate the visitor/staff. Informed the AHA that upon entering the facility, SSA1 and SSA2 were not asked the screening questions prior to giving both surveyors stickers which indicated the surveyors were thoroughly screened. On 05/19/20 at 10:15 AM, reviewed documentation provided by the facility regarding screening provided by the facility reglement of fill the provided by the facility regarding screening process. According to documentation screening process. According to documentation screening process by Sealt were also re-in-serviced on the COVID 19 entry screening following the COVID quildelines. In screening the screening staff should ask anyone who enters the security guard had to leave his post. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. Managers were instructed to check screening process by Security and report any concerns to COVID 19, incident command members have added an agenda item to the daily meeting to discuss any CDC updates and
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG	CASID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES CACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE TAGE) CACH CORRECTIVE ACTION SHOULD BE CACH CORRECTION SHOULD BE CACH CORRECTIVE ACTION TO ACCH AND ACTION TO ACTION TO ACTION TO ACTION TO ACTION TO ACTION TO ACTIO
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further evaluate the visitor/staff. Informed the AHA that upon entering the facility, SSA1 and SSA2 were not asked the screening questions. AHA confirmed SS1 should have asked SSA1 and SSA2 the CDC screening questions prior to giving both surveyors stickers which indicated the surveyors were thoroughly screened. On 05/19/20 at 10:15 AM, reviewed documentation provided by the facility regarding screening process. According to documentation screening staff should ask anyone who enters the facility the following? 1. cough, 2. Shortness of breath or difficulty breathing, 3. fever, 4. chills, 5. repeated shaking with chills, 6. Muscle pain, 7. Headache, 8. Sore throat, 9. New	further evaluate the visitor/staff. Informed the AHA that upon entering the facility, SSA1 and SSA2 were not asked the screening questions. AHA confirmed SS1 should have asked SSA1 and SSA2 the CDC screening questions prior to giving both surveyors were thoroughly screened. On 05/19/20 at 10:15 AM, reviewed documentation provided by the facility regarding screening process. According to documentation screening staff should ask anyone who enters the facility the following: "In the last 14 days, have you had any of the following? 1. cough, 2. Shortness of breath or difficulty breathing, 3. fever, 4. chills, 5. repeated shaking with chills, 6. Muscle pain, 7. Headache, 8. Sore throat, 9. New loss of taste or smell, 10. Have you been in close contact with someone with confirmed COVID-19, 11. Do you have any reason to believe you might have or have been exposed to COVID-19, 13. Have you been tested for COVID-19, 14. Any recent travel. People who answer yes to 1, 2, 10, 11, 12, 13, 14 or yes to at least two of the symptoms numbered 3 through 9 may have COVID-19. Notify charge nurse who will do a further assessment." The procedure form documents staff is to screen and check temperature while person is still outside of the facility. However, SSA1 and SSA2 were screened inside of the facility. The procedure document also indicates that screening staff review poster of signs and symptoms and
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contact with someone with confirmed COVID-19, 11. Do you have any reason to believe you might have or have been exposed to COVID-19, 12. Have you been tested for COVID-19, 13. Have you tried to get tested for COVID-19, 14. Any recent travel. People who answer yes to 1, 2, 10, 11, 12, 13, 14 or yes to at least two of the symptoms numbered 3 through 9 may have COVID-19. Notify charge nurse who will do a further assessment." The procedure form documents staff is to screen and check temperature while person is still outside of the facility. However, SSA1 and SSA2 were screened inside of the facility. The procedure document also indicates that screening staff review poster of signs and symptoms or ask systematic changes made to ensure that the deficient practice will not recur. Managers were instructed to check screening process by Security and report any concerns to COVID 19, incident command meeting. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. i.e. what program will be put into place to monitor the continued effectiveness of the systematic changes made to ensure that the deficient practice will not recur. Managers were instructed to check screening process by Security and report any concerns to COVID 19, incident command meeting. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. i.e. what program will be put into place to monitor the continued effectiveness of the systematic changes. COVID 19, incident command members have added an agenda item to the daily meeting to discuss any CDC updates and concerns on the screening process and will put into place corrective action immediately.	requesting entrance to the facility. SS1 did not will put into place corrective action

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STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION DEPICE	Hawaii Dept. of Health, Office of Health Care Assurance						
AND PLAN OF CORRECTION 125031 A BUILDING: B. WING OS/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 54-383 HOSPITAL ROAD KAPAAU, HI 98735 (PAPAU, HI 98735 (PAPAU, HI 98735 COMPLETED OSAPPETIX TAG OSS-REFERRECTED TO THE APPROPRIATE DATE OCOMPLETE DATE DATE DATE OCOMPLETE DATE DATE DATE DATE DATE DATE DATE D	STATEMENT	, ,		(X2) MULTIPLE			
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container listed hydrogen peroxide as main							
ingredient to use as bactericidal and virucidal in		•	• .				
		•	actericidal arid virucidal iri				
one minute.		one minute.					
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Policy and procedure (P&P) for sanitizing							
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Disinfection of Shared Medical Equipment,"							
approved on 05/11/20, mandated under							
"PROCEDURES: The staff will follow							

Office of Health Care Assurance

manufacture guidelines and use appropriate

STATE FORM 6899 7ECM11 If continuation sheet 4 of 5

PRINTED: 06/12/2020 FORM APPROVED

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED		
		125031	B. WING		05	5/20/2020	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
KOHALA	KOHALA HOSPITAL 54-383 HOSPITAL ROAD KAPAAU, HI 96755						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
4 203	cleaning products' manufacture guideling instructions for, "Cleat outside with a soft clot and mild detergent. I another solvent to clet glucometer was not no	Requested the glucometer es and the manufacturer ning your meter wipe the oth dampened with water to not use alcohol or ean your meter." The made for use by multiple re did not have instructions	4 203				

Office of Health Care Assurance

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